THE PHILADELPHIA NEUROLOGICAL SOCIETY.

November 26, 1901.

The President, Dr. James Tyson, in the chair.

Brown Séquard Paralysis.—Dr. Dercum presented a case of this form of paralysis resulting from spinal syphilis.

Dr. William G. Spiller said that the early appearance of the spinal symptoms after primary infection was of interest, as the man still had the syphilitic eruption on his body. The preservation of tactile sense was important. Probably in most cases of Brown-Séquard palsy, tactile sense is preserved on both sides of the body, whereas the temperature and pain senses are lost on the side opposite the lesion in the cord.

A Case of Myelitis exhibiting the Results of Coördination Exercises.—Dr. John K. Mitchell read a paper with this title, and presented the patient. (See page 34.)

Dr. Charles W. Burr remarked that he had seen this patient shortly after his disease had developed, and that the improvement since that time had been very great. The patient, at first, was very spastic, and walked with great difficulty; his knee-jerks were greatly increased, and he had ankle-clonus on each side, but no muscular wasting.

Dr. F. Savary Pearce said that he had seen this patient several times in the dispensary, and had been a witness of the great improvement that had occurred. On one occasion he had seen the patient crossing the street, and had observed the great difficulty he had in stepping up on the curb, on account of the extreme spasticity that existed. Dr. Pearce believed that the movements which had been described were largely responsible for the great improvement in coördination.

Dr. H. A. Hare inquired whether Dr. Mitchell had had the opportunity to investigate the question as to the frequency with which myelitis is a complication of typhoid fever.

Doctor J. K. Mitchell agreed with Doctor Hare that myelitis must be a very rare complication of typhoid fever. He had seen but one other case and that a doubtful one. He considered the present case a doubtful one, and he had been careful to state that the myelitis had followed typhoid instead of saying that it had been a consequence of the fever. It was to be noted that the myelitis had not appeared until at least two months of apparently perfect health had elapsed after the recovery from the typhoid. He thought it to be regretted that the spinal puncture had been unsuccessful, as an examination of the spinal fluid might at least have contributed some negative testimony.

Post-apoplectic Hemihypertonia.—Dr. D. J. McCarthy presented a patient with tonic spasms of the hand and foot on the same side, occurring at irregular intervals. This condition had developed after an apoplectic attack.

Dr. William G. Spiller remarked that this condition of post-apoplectic hemihypertonia was not well recognized. He had reported the first case in this country, and one other had been referred to by Dr. F. A. Packard. In these cases the contraction is not persistent. It varies in intensity from time to time. At one moment it may be marked, and the next it has disappeared. There is not much motor paralysis in these cases. It is a condition of excessive muscular tonicity, and probably is the result of a lesion near, but not in, the motor tract within the cerebral hemisphere. The central motor fibers are irritated and not destroyed. The contractions are unlike those of athetosis or chorea.

Brain Tumor.—Dr. Wm. G. Spiller presented a patient with many of the symptoms of brain tumor.

Dr. Charles K. Mills thought it probable that this was a case of tumor in the motor region, cortical or subcortical. He wished to call attention to a diagnostic method which had been employed in a case under his care at the Philadelphia Hospital. The patient, a woman, had all the classical symptoms of brain tumor. Apparently, it was a large tumor, the central or initial portion of which was in the parietal region. Dr. G. E. Pfahler, one of the resident physicians, had made use of the X-ray apparatus and had obtained a shadow of the tumor in the region where it had been located by a study of symptoms and signs of focal disease. An operation for the removal of the tumor was done in this case, and the tumor was found in the region in which it had been believed to exist. A fuller report will be made later.

Dr. A. A. Eshner remarked that it might interest Dr. Spiller to learn that his patient had been at the Orthopedic Hospital before she came under his care. At that time there were present symptoms of right hemiplegia, with tremor in the upper extremity on that side. The case was at first regarded as probably hysterical in character, but subsequently it was concluded to have an organic basis. There was no record of an ocular examination.

Dr. Charles W. Burr said that in the early stage of many cases of brain tumor it was not surprising that the symptoms should be attributed to hysteria. In his own personal experience he had several times said that patients were suffering from hysteria when further examinations showed positive evidences of new-growth.

Dr. William G. Spiller remarked that it was easier for the physician who sees these cases in the advanced stage to make a diagnosis than for the one who sees them in the earlier periods. It was only after examining his patient several times that he became suspicious that the "tremor" might be a manifestation of Jacksonian epilepsy, and he had then urged her to come into the hospital.

Cholesteatoma of the Brain.—Dr. C. L. Allen presented a tumor of this character.

Dr. William G. Spiller said that these tumors are more likely to occur at the base of the brain, and they may exist without causing symptoms. He thought that it was a cholesteatoma because of its friability, its pearly luster, its position, the presence of numerous cholesterine plates, the large epithelial-like cells without nuclei, and the distinct layers of cornefied cells. The recent paper of Dr. J. J. Thomas contains the description of three similar tumors.

Report of a Case of Aphasia.—This report was made by Dr. C. W. Burr. One peculiarity of the case was that only the important words of a sentence were spoken.

Dr. Charles K. Mills said that this patient had come into the hospital during his term of service, and he had made a somewhat elaborate study of his condition. The point of interest was as to the seat and extent of the lesion that had caused these strange speech phenomena. Dr. Dercum had a similar case some years ago, on which Dr. Mills thought a trephining operation had been done later.

Mary Putnam Jacobi had reported a similar case and others were on record. These cases impressed Dr. Mills with the fact that the cerebral speech zone, as he had long contended, was more complex than would be indicated by those who believe that we have simple percept centers, and motor speech and executive centers. He thought that these cases helped to show that between this region of percepts and of motor speech there is another region. He did not think that any lesion of the percept centers, or of the motor centers, or merely of the conducting tract between these simple centers would explain this case. It would be explained by some as a case of conduction aphasia. He was inclined to say that in this case the lesion was between what is termed the concept or naming center, and Broca's center—and that it was in this sense a conduction aphasia. This patient was never word-deaf. He doubted if it ever was a true case of word- or letter-blindness, at least of the "center" variety. He did not doubt that the man had apparent word-blindness and letter-blindness. The patient had not interference with the executive center for speech, and the evidence was not clear that Broca's center was involved, except as we recognise that all centers must have the axones which come from other regions come in contact with the cell-bodies of the region in question. A partial lesion of Broca's convolution could explain the case, but after all that is a conduction lesion in the proper sense.

An interesting fact was that this man in addition to the speech defect had had a number of attacks of monospasm affecting the face and arm and sometimes the leg, but the face most prominently. The region where the fibers cross from the temporal lobe to reach Broca's convolution is not known, but it is possible that they cross at the retroinsular convolution. A hemmorhagic or other lesion here might affect the neighboring region of the face.

Dr. F. X. Dercum thought that the explanation advanced by Dr. Mills was a most plausible one. A point in favor of conduction aphasia is that the patient preserved the simple associations. If these are started, he could go on as in naming the days of the week, the months, etc. It seemed to be a difficulty in bridging across the perceptive areas and the emissive area, rather than a lesion of either area. Just where the trouble was, was a matter of conjecture.

The case resembled one reported by the speaker some time ago. This was a case of hemiplegia in which a man had aphasia, total except that he had a fair memory for nouns. The patient was an engineer, and when asked as to his occupation would reply, "boiler, water, wood, coal, fire, steam." If asked as to his early life, replied, "farm, country, errands, work." He could also pick out words that were called for from a printed page.

Dr. William G. Spiller, who had seen this man a number of times, called attention to the fact that he had been carefully trained to speak. The case impressed Dr. Spiller very much like that of a child learning to speak. He thought that as a result of education the right speech center might have been developed, as the man was very young. In this case there had been no paraphasia, which is present in cases of sensory aphasia without motor aphasia.

Dr. Charles W. Burr said that he had tried in every way to prove that this man understood what he could not utter. When he saw C or D it was not that he understood but could not utter the sound, but the sign did not produce any idea whatever in his mind. X, B and O were the only letters that he could understand, and these he could pronounce. A few isolated words he read, not as words, but as pictures. Dr. Burr believed that there was not only apparent word-blindness, but actual word-blindness. The patient gained somewhat under training, but when the training ceased, he lost what he had gained. He had now been training himself and was beginning to learn again.

The Direct Ventro-lateral Pyramidal Tract.—Dr. Wm. G. Spiller read a paper on this tract described by him in 1899, and stated that Stanley Barnes had recently found this tract degenerated in four cases of hemiplegia.

Dr. D. J. McCarthy said with regard to the tract reported by Russell, that it corresponded with a tract which he (Dr. McCarthy) found while working on a case of cerebellar lesion in Flechsig's laboratory. This tract corresponded very closely to that of Dr. Spiller, except that it was situated more anteriorly in the cervical region of the cord. It was followed up and found to have a lateral position to the olive. The presumption was that it went farther up through the pons. There were so many hemorrhages in the tissue that it was considered unadvisable to go on with the study of the case. Flechsig was of the opinion that this tract came from the cerebellum.

Dr. William G. Spiller remarked that there were a number of tracts situated in the ventro-lateral region of the spinal cord, and that unless they were followed to their origin, it could not be said what tracts they were.